

VOLVULUS OF THE JEJUNUM.

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Miss M. W., an adult, had had dyspepsia for several years; otherwise her health had been good. After eating a boiled dinner of cabbage, corned beef, and potatoes, she had severe "cramps" in the abdomen. These "cramps" resembled "colicky pains." Moving about in the bed and doubling herself over—that is, drawing her knees up to her abdomen—seemed to temporarily afford relief, but the colicky, crampy pains continued. These colicky, crampy pains were intermittent, easing up a little and then recurring with renewed force. She vomited, she had extreme nausea, she had many loose movements from the bowel. None of these movements contained blood. The vomiting and the "dry heaving" continued all night. I saw her upon the third day of the attack. She looked sick, she presented a peritoneal facies, her features were drawn, the angles of her mouth and alæ nasi were depressed, there was a little black vomitus on the lips and chin, the abdomen was distended, the umbilicus was flush to the level of the abdominal wall, the abdomen was tympanitic throughout. No tumor could be felt.

Operation discovered an almost black coil of the jejunum, about two feet long, twisted at its mesenteric attachment. (Fig. 1.) Upon untwisting this volvulus, its exact extent was determined. It was found, as is seen in the photograph, to extend up to within about two inches of the beginning of the jejunum and thence down for two feet. (Fig. 2.) The condition of the patient precluded the possibility of further interference. The abdomen was closed and the woman died.

This case serves to illustrate the very great importance of a careful, discriminating analysis of abdominal pain. Had this case been operated at the onset of the attack, the chances of recovery would have been good. The several hours' delay caused the death of the bowel, tremendous shock to the individual, and



FIG. 1.—Volvulus of jejunum seen untwisted, but in same situation as found at operation.



FIG. 2.—Thrombosis of the mesenteric vessels due to *volvulus* of the jejunum. Note upper boundary of gangrene of gut close to jejunal origin. Omentum and transverse colon drawn upward, showing mesocolon and beginning of jejunum.

precluded the possibility of surgical relief. The pain in this case was typical of a mechanical obstruction. It was not possible to make a diagnosis of volvulus or of a band, but that there was a mechanical obstruction from some cause there was no doubt.

This case is recorded because the volvulus of the jejunum was high, which is unusual. I suppose that the shock from the high situation of the volvulus must have been great, and decidedly greater than from a volvulus seated in a lower portion of the small intestine. In a case with such a high situation of the volvulus arises the question, What is the best surgical treatment? Had the case been seen early and had the bowel been viable, a simple untwisting of the volvulus would have been all that was necessary, but with the bowel gangrenous so close to the jejunum, it was a question as to the wisest operative procedure. A resection of the gut, an anastomosis with a Murphy button, or a resection of the gut and closure of the jejunum at the proximal end, and an anastomosis of the distal jejunal end into the duodenum might have been the best procedure.

After dividing the gut at the jejunal origin, it might be possible to divide the peritoneal reflection and to free the last part of the duodenum sufficiently to facilitate the use of the Murphy button. I shall do this experimentally upon the cadaver in order to determine if this is feasible.

The pathological report from the Pathological Laboratory at the Massachusetts General Hospital, so far as the case surgically is concerned, was as follows: Obliterating thrombosis of the superior mesenteric vein; hæmorrhagic infarction of a portion of the jejunum. The first portion of the jejunum over a distance of about seventy centimetres is dark purple in color, and its mesentery is thickened and purplish in color. At its upper and lower margins it is rather sharply marked off from the duodenum and from the remaining portion of the jejunum, the lower line of demarcation being less sharp than the upper. (Fig. 2.)